GUTTMACHER INSTITUTE

Contraception Counts

Tennessee

The United States has one of the highest rates of unintended pregnancy in the industrialized world. Half of the six million pregnancies that occur among American women each year are unintended; of these, 1.3 million end in abortion.

What explains this high level of unintended pregnancy? About half of unintended pregnancies occur among couples who were using a contraceptive method in the month the woman became pregnant; either the method did not work properly or the couple did not use it consistently or correctly. Because the likelihood of pregnancy in the absence of contraception is high, the other half of unintended pregnancies occur among the one in 10 sexually active, fertile women who were not using any birth control method even though they were not trying to become pregnant.

Recognizing the personal, social, economic and medical toll associated with unintended pregnancies, the federal government has established a national public health goal to reduce by 40% the proportion of pregnancies that are unintended by 2010. It also has identified family planning as the key to achieving this objective.

States can play a major role in helping women to avoid unintended pregnancy—particularly low-income women, who are more likely than those who are better-off to experience an unintended pregnancy and to rely on publicly supported services for their contraceptive care. Accordingly, the Guttmacher Institute assessed the states (and the District of Columbia) on their efforts to help women obtain contraceptive services and supplies, and to use them consistently and correctly over time. States were scored and ranked on three indicators:

• *service availability*—how well the states meet existing need for subsidized contraceptive services and supplies;

• *laws and policies*—whether their laws and policies are likely to facilitate access to contraceptive services and information; and

• *public funding*—the extent to which they devote their own revenues, and leverage potential federal dollars, to support the delivery of publicly supported contraceptive services and supplies.

Scores on all three indicators were aggregated, and an overall rank was assigned to each state. Additionally, the states were ranked according to the progress they made between 1994 and 2001 in service availability and public funding. Tables that contain the results of these rankings across the 50 states, as well as descriptive information for all states on pregnancies, their outcomes and the need for publicly supported contraceptive services, can be found at www.guttmacher.org.

Pregnancies and Their Outcomes

• In Tennessee, 114,530 of the 1,253,020 women of childbearing age become pregnant each year. 70% of these pregnancies result in live births, and 15% result in abortions; the remainder end in miscarriage.

• Tennessee has the 18th highest teenage pregnancy rate of any state. Of the 17,070 teenage pregnancies each year in Tennessee, 67% result in live births and 18% result in abortions.

Among the 50 states and the District of Columbia, Tennessee ranked

- 30th in service availability;
- 42nd in laws and policies;
- 20th in public funding; and
- 38th overall.

• Tennessee's teenage pregnancy rate declined by 20% between 1992 and 2000.

The Need for Publicly Supported Services

• In Tennessee, 640,950 women are in need of contraceptive services and supplies. Of these, 333,180 women need publicly supported contraceptive services because they have incomes below 250% of the federal poverty level (236,170) or are sexually active teenagers (97,010).

• In Tennessee, 19% of women aged 15–44 have incomes below the federal poverty level, and 17% of all women in this age-group are uninsured (i.e., do not have private health insurance or Medicaid coverage).

• In Tennessee, 17% of women aged 15–44 are enrolled in Medicaid.

Service Availability

• In Tennessee, 189 publicly funded family planning clinics provide contraceptive care to 102,870 women—including 37,770 sexually active teenagers.

• Family planning clinics in Tennessee serve 31% of all women in need of publicly supported contraceptive services and 39% of teenagers in need.

• 100% of counties in Tennessee have at least one family planning clinic.

Funding for Publicly Supported Services

• In 2001, the federal and state governments together spent $31,767,000 in Tennessee on contraceptive services and supplies. Of this amount, 10% was allocated to contraceptive services at the state's discretion. (The funds came from either state revenues or federal dollars under the state's control.) The remainder came from the federal government.

• In Tennessee, $112 was spent on contraceptive services and supplies per woman in need (adjusted for the cost of health care in the state).

Impact of Publicly Supported Services

• Publicly funded family planning clinics in Tennessee help women prevent 24,000 unintended pregnancies each year.

• Every public dollar spent on family planning services saves the federal and state governments three dollars in Medicaid costs for prenatal and newborn care.

The Key Role of Title X

• Title X of the Public Health Service Act, the only federal program devoted solely to the provision of publicly supported family planning services, supports 130 family planning clinics in Tennessee. These clinics serve 81,730 women, including 30,310 teenagers.

• Title X–supported clinics in Tennessee help women avert 19,000 unintended pregnancies each year.

Tennessee's laws and policies addressing contraception

Policy options	Type and quality of policy*
Expanded Medicaid eligibility for family planning services	**Neutral**
For individuals with incomes up to a state-specified level	
Only for all or certain individuals losing Medicaid coverage	
No expansion	✔
Insurance coverage of contraception	**Neutral**
Mandate for all insurers	
Mandate that includes a broad refusal clause	
Mandate that excludes emergency contraception	
No policy, or mandate that covers only a limited segment of the insurance market	✔
Access to emergency contraception	**Neutral**
Available from pharmacists through a collaborative practice arrangement	
Discussion or provision in emergency rooms required	
No policy	✔
Minors' consent law	**Best**
All or most minors can consent to contraceptive services	✔
No policy, or only certain classes of minors can consent to services	
Sex education policy	**Worst**
Requires contraceptive education statewide	
Requires abstinence education statewide	✔
Requires contraceptive education in school districts with sex education	
Requires abstinence education in school districts with sex education	
Rejects federal abstinence-only education funds	
Restrictions on family planning funds	**Best**
No restrictions	✔
Separation of abortion and state-funded family planning services required	
Parental consent required for state-funded contraceptive services to minors	
Refusal clause for contraceptives	**Worst**
No policy	
Applies to individual health care providers	✔
Applies only to pharmacists (without consumer protections)	
Applies to health care institutions	✔

*Quality refers to the extent to which the policy enhances or hinders access to and use of contraceptive supplies and services. Possibilities are best, good, neutral, bad and worst.

Methodology and Sources

This fact sheet contains the most current data available as of November 1, 2005. To construct the indicators used for ranking state efforts, we included two service availability measures (the proportion of women in need served by clinics and the proportion of counties with at least one clinic) and two public funding measures (the proportion of total funding allocated by the state and the total funding per woman in need). Each measure was standardized to range from 0 to 100. A summary score for each indicator was obtained by averaging the two applicable measures. An indicator of laws and policies was constructed by summing state scores across seven policy areas. Finally, an overall composite score was constructed by averaging the summary scores for the three indicators, giving equal weight to each. Detailed references, definitions of terms used in this fact sheet and a complete description of the methodology are available at www.guttmacher.org.

More information on both women in need of contraceptive services and publicly funded family planning clinics in Tennessee is available at www.guttmacher.org.

Credits

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